**“Mind, madness and melancholia:**

**Ideas and institutions in psychiatry from classical antiquity to the present”**

A joint meeting of the Royal Society of Medicine (RSM) Psychiatry Section

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**Selected Summaries[[1]](#footnote-1)**

**compiled by Howard Ryland**

**Mind, madness and melancholia. Ideas and institutions in Classical Greece and the Hellenistic world**

**Glenn W. Most**

The history of the treatment of mental and other illnesses during the course of Greco-Roman antiquity is often viewed as a paradigmatic case of the development from *mythos* to *logos*, from a pre-rational, mythical worldview to a genuinely scientific one of the sort that we in the modern West like to consider to be our own. Put in these terms, such a triumphalistic view is a misleading over-simplification: for first, the various ways of treating mental disorders that one can already identify in earliest times – religious purifications, speaking with the patient, turning to various kinds of experts – continue through the end of antiquity; second, the Hippocratic texts indicate more a one-time medicalization through the functional differentiation of a new set of specialists, followed by centuries of very little change, rather than a continuous development of modes of rationalization; and third, the basic Hippocratic and Galenic medical concepts, the four humors, are much more metaphysical postulates than empirically available medical realities. A mythic or religious view according to which such disorders are thought to be the work of the gods, who punish someone for his own crime or an ancestor’s, and in which they are temporary episodes that can be healed by cultic remedies, continues to the end of antiquity, as evinced by such inadequately studied evidence as inscriptions, private letters, amulets, and curse tablets. Next to this popular view, there grows up a medical view that is rather different in orientation: it seeks causes not in divine punishment but in a humoral imbalance; it argues in terms of natural phenomena that are always present and can affect anyone; it considers chronic conditions and personality types; and it seeks remedies in mechanical procedures like purgations intended to restore the natural balance. And yet even Galen, the greatest physician of the pre-modern world, demonstrates and in part recognizes the limitations of his humoral approach to these illnesses, and thereby also the limits to the effectiveness of ancient medicine in dealing with them.

**Madness in Rome, Law, Literature and Medicine**

**Vivian Nutton**

Discussions and descriptions of madness in the Roman world depend almost entirely on earlier Greek literature. Even Roman law, which has a good deal to say about madness and mental incapacity, has parallels in Athenian law, while Latin literature is filled with stories from earlier Greece. But this is hardly surprising since by 150 AD the city of Rome was home to many thousands of Greeks, while the Roman Empire was a bilingual empire. Many communities conquered by Rome believed in demoniac possession, and religious explanations co-existed alongside non-religious ones. Methodist medicine, a largely Roman creation, introduced new ideas on madness, while the later more famous followers of Hippocrates, such as Galen and Rufus of Ephesus, offered new insights, particularly insisting on the need for the doctor to work alongside the patient and to take seriously his or her concerns, however strange they might be.

**DEGENERATION: Victorian Psychiatry’s Science of Shame and exclusion**

**Anthony Fry**

By 1850, mental disorder was being linked to brain pathology. This was hailed as an important scientific innovation. It was associated with studies of tertiary syphilis, of brain localisation by Meynert and Wernicke, and Alzheimer’s pioneering work in Germany, in relation to dementia. Such brain changes, we would now call ‘organic’. At last there was hope of an end to superstition and humoral theory, and, with science, a new humane approach and the promise of cure.

However, quite soon these neuropathological developments had been conscripted into an elaborate theory of mental disorder linked to evolutionary decline known as Degeneration. These theories were used not only to explain mental illness, epilepsy and imbecility, but also “perversion”, personality disorder and criminality, and occasionally creative genius, as in the case of Oscar Wilde.

The population of Europe was seen by Morel, Spencer, and Hughlings Jackson, to be in the process of genetic and evolutionary decline, manifesting as immorality and criminality.

The ideas of Lamarck were used to support the role of social immorality, by mechanisms then unknown, in adversely altering the genetic material. Darwinian ideas were cited to support regression, the decline of civilised European humanity back to their ape ancestors.

Whilst demonic possession had been discounted three hundred years earlier as an explanation for insanity, the devil was soon back, but in a rather different form. What started as innovation driven by important neuropathological discoveries, became linked with ideas of evolutionary decline and impurity.

These Degenerates, especially the mad, the criminal and those who were not heterosexual, were stigmatised and ostracised. Many were moved into asylums, but as there was no effective treatment, the asylums were soon overcrowded and declined, and were frequently brutal, inhumane and immoral.

At the time of Oscar Wilde’s imprisonment for gross indecency, a leading psychiatrist Max Nordau (1849-1923) published work on Degeneration, which appeared in an English edition in 1895 and cited Wilde as an exemplar. It was widely applauded, particularly by Henry Maudsley, whose sexual attitudes were bizarre to say the least, and who diagnosed Wilde as suffering from erotomania and masturbatory innsanity and described him as an abomination to mankind, hardly medical science.

This represents a tragic and shameful chapter in the history of psychiatry. What had begun as a humane and scientific attempt to identify the brain as the source of mental illness soon became tinged with moralising, a pervasive and doom-laden fatalism, and the segregation of the insane, without rights, into asylums for the incurable.

Now neuropathology and neuropsychology are back. Psychopathy has been linked to cortical thinning and to fronto-amygdala tract defects. This is surely Degeneration – but with another name.

Autism, conduct disorder, IQ, and a whole variety of other disorders have genetic and neuropathological determinants. Epigenetic factors switch on and off key genes which are very relevant to schizophrenia and other psychiatric disorders.

Post-modern political correctness seems to prevent even identifying some disadvantaged groups, who are concealed by new sanitised euphemistic diagnostic categories. Without identified disadvantage can they ever be any better off?

The asylums were closed. Many have become luxury apartments. Those who used to occupy them were moved to small group homes and day hospitals. Before long they were out on the streets – sleeping rough! Lost to follow up! Out of sight out of mind!

We have gone full circle, the brain is back and environment really does alter genetic expression. Can selfhood, intent, responsibility and free will survive, or are we deterministic robots built of flesh? Robots do many tasks better than humans. The criteria for social inclusion are ever more demanding and the mentally ill move down the priority list as resources are cut and waiting times lengthen. But might we this time, with all these new discoveries do rather better than the Victorians? We have to!

**Kathleen Jones’ *Asylums and after*: a neglected masterpiece on the history of psychiatry?**

**George Ikkos**

Written by a retired Professor of Social Policy and former Chair of the British Social Work Association with strong Christian Socialist convictions, *Asylums and after: a revised history of the mental health services: from the early 18th century to the 1990s* offers valuable insights on the role of 19th century religious concerns in the creation of the asylums, the history of parliamentary debates in shaping mental health services and law, and the significance of economics and libertarian political philosophy in bringing about the move from asylum to community psychiatry in the second half of the 20th century. Enriched by Kathleen Jones’ committed writing and intimate knowledge of the field in practice as well as scholarship, the book deserves a wider readership. However, her staunch defence of the asylums, overwhelmingly negative appraisal of the “anti-psychiatry” movement of the 1960s, and rather muted response to patient experience in the face of medical authority deprive it of the status of “masterpiece”. The more liberal concerns of critics of psychiatry such as Erving Goffman and Michel Foucault remain relevant to contemporary mental health services which combine elements of de-institutionalisation with re-institutionalisation and hyper-institutionalisation.

**De-institutionalisation and community care in the UK since 1960: good and bad?**

**Tom Burns**

Community Psychiatry in the UK evolved alongside de-institutionalisation. It is a moot point which stimulated which. The unique shape of UK provision was formed by the 1959 MHA which welded social care into the mix. This essentially forced sectorisation, which has dominated development for several decades. However its character stemmed from the distinct anti-authoritarian and relatively anti-expert spirit of therapeutic community and social psychiatry thinking of the time. Much of this spirit, with its emphasis on informality and role blurring, has persisted within the multidisciplinary team for good and ill. The generic multidisciplinary team, with its flexibility and ease of outreach, has repeatedly proved its worth for patients in the era of evidence-based medicine. However the model has not been without unintended consequences for the profession and for service development. These include a loss of status and self confidence within psychiatry, a surprising tolerance of woolly thinking and a loss of professional authority resulting in the imposition of endless poorly thought out managerial reorganisations.

**Sustainable psychiatry**

**Daniel Maughan**

Our society lives beyond its means, from a planetary resource perspective. This over-consumption combined with the ongoing population explosion combine to negatively affect global ecosystems, such that issues of climate change, drought, and desertification have started to affect human health on a mass-scale. The Word health Orgnaisation and the Lancet Commission have both stated that climate change is likely to be the largest threat to human health in the 21st century, and health care is contributes very significantly to this. For instance, 10% of the emissions from the US are due to health care; health care has a massive carbon footprint. The NHS has a larger carbon footprint than medium sized European countries like Slovenia or Estonia and is the largest contributor of emissions in the public sector in the UK. Most of the carbon footprint of health care is made up of clinically related factors. Medication is the single largest component of the carbon footprint of the NHS, followed by medical equipment. Doctors need to start realising the importance of designing models of care that take environmental factors into account, as otherwise our very actions as health care professionals will be undermining human health through the emissions produced by the care we provide. We need to embed the principles of sustainable health care, which are prevention, empowerment, improving value and considering carbon. These principles are ordered according to their ability to reduce the carbon footprint of health care. We need to critically analyse our services to assess whether these principles are fully embedded to ensure that our services are sustainable.

1. Also, see report in HoPSIG *News and Notes*, November 2016. [↑](#footnote-ref-1)